1POINT SOLUTIONS

Recurring Expense Service Form

INSTRUCTIONS: This form is used to request your Dependent Care Account contributions be reimbursed to you on a per pay period basis. By completing this form you will not need to provide continuing documentation. Please complete all fields and include appropriate documentation stating your child will be attending throughout the year or specific time frames. **All information must be completed by you & your Dependent Care facility to receive reimbursement. CLAIMS WILL NOT BE PROCESSED WITHOUT YOUR SIGNATURE AND THE PROVIDERS SIGNATURE.**

1. Declaration of Services

I request reimbursement for the below listed time frame for qualified

☐ Dependent Care Services

I certify that the services will be provided between the following dates:

_____ to _____

Start Date of Services (MM/DD/YY) — End Date of Services (MM/DD/YY)

I have included signed copies of the independent provider's charges, which will include the total amount of $ _____ for the dates provided above.

Total Amount of Services

NOTE: If you have any changes during the dates referenced above please notify 1Point Solutions at 615-242-1900 x 2 or email fsa@1pointsolutions.com.

2. Participant Information

Name of Participant		Social Security Number	
ADDRESS Street	City	State	Zip
Phone Number ( ) -		E-Mail Address	
Name of Dependent			

3. Care Provider Information

Name of Dependent Care Expense Provider			
ADDRESS Street	City	State	Zip
Federal Tax ID			

11/16/04

4. Signatures

_____ _____

Authorized Signature of Provider — Date

_____ _____

Participant Signature — Date

PLEASE NOTE: Your total reimbursement amount will be figured on the amount which you have elected for the year based on the amount of payrolls that occur throughout the plan year. For questions regarding your maximum contribution amount, please contact 1Point Solutions Customer Service at (615) 242 – 1900 option 2.